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ABSTRACT

This working paper is one of eleven individual research reports in which researchers with expertise in older adult populations gathered the most current available data, examined policies, regulations, and programs relevant to population aging and older Californians, and presented findings and recommendations. The issues examined-- economic well-being, work and retirement, housing, transportation, health status, mental health status, long-term care, residential care, family caregiving, and successful aging--encompass most of the key issues concerning an aging population and California's principal responses to its senior citizens. The report notes that the state's efforts toward meeting the needs of older adults with mental illnesses must be improved. Programs must be expanded so that more older adults can be served. Further, the report features pertinent efforts made by universities and private organizations, and argues that these organizations assume a critical role in providing for the well being of the older population. Finally, three emerging issues that warrant further attention are highlighted: the increasing diversity of the aging population; the expansion of managed mental health care; and the development of a statewide system of mental health care for older adults. (Contains 60 references and 2 tables.) (GCP)

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WORKING PAPER

Promoting Mental Health, Preventing Mental Illness, and Providing Effective Psychological Treatment to California's Aging Population

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Brian Kaskie and Susan Ettner

Strategic Planning on Aging

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The California Policy Research Center (CPRC) is a University of California program that applies the extensive research expertise of the UC system to the analysis, development, and implementation of state policy as well as federal policy on issues of statewide importance. CPRC provides technical assistance to policymakers, commissions policy-relevant research, and disseminates research findings and recommendations through publications and special briefings.

This working paper is part of a state-commissioned project undertaken after California enacted Senate Bill 910 (Vasconcellos, Statutes of 1999, Chapter 948), which mandated the Secretary of Health and Human Services to develop a strategic plan to address population aging. It is one of 11 individual research reports commissioned during phase one of the three-year project, during which researchers with expertise in older adult populations gathered the most current available data, examined policies, regulations, and programs relevant to population aging and older Californians, and presented findings and recommendations. The issues examined—economic well-being, work and retirement, housing, transportation, health status, mental health status, long-term care, residential care, family caregiving, and successful aging—encompass most of the key issues concerning an aging population and the state's principal responses to its senior citizens. They form the basis of a policy overview report called *Strategic Planning Framework for an Aging Population.*

Summaries of these working papers and the policy report are being published in a special 12-part *CPRC Brief* series, Strategic Planning on Aging. The views and recommendations in this report are those of the authors and do not necessarily represent those of CPRC or the Regents of the University of California.

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EXECUTIVE SUMMARY

As the 21st century begins, there are more than 700,000 older Californians that require specialty mental health care, and this number may triple by the year 2020. The specific challenges concerning the psychological well-being of the aging population involve the promotion of mental health, prevention of mental illness, and provision of effective psychological treatment.

The state has addressed these matters through programs administered by the departments of Aging, Health Services, Mental Health, and Social Services. The California Legislature also has taken steps toward meeting the needs of older adults with mental illness. However, we determined that these efforts must be improved. Programs must be expanded so that more older adults can be served. The State also should reconcile how recent reforms to the state Department of Mental Health and the Medi-Cal program have decreased access to publicly funded mental health services for the older population. Further, we featured pertinent efforts made by universities and private organizations, and argued that these organizations assume a critical role in providing for the well-being of the older population. Finally, we illuminated three emerging issues that warrant further attention. These included: (a) the increasing diversity of the aging population, (b) the expansion of managed mental health care, and (c) the development of a statewide system of mental health care for older adults. If strategic planning efforts can address these particular issues, then the psychological well-being of California's aging population would be enhanced substantially.

INTRODUCTION

The United States Surgeon General (2000) recently proclaimed that mental health is fundamental to overall health and well-being, and the effects of mental illness can be just as detrimental and disabling as cancer or any other serious health problem. Mental illness impairs functional ability, limits occupational and leisure opportunities, lowers health status, and may be a source of stress and burden to significant others and caregivers. Gottlieb (1992) also suggested that mental illness represents a significant cost to the older individual and to society. Lifetime earnings of an individual with mental illness may be diminished, and his or her out-of-pocket spending for specialized treatment can be substantial. Insurance providers allocate as much as 15% of their annual budget for mental health and substance abuse services, and employers are challenged by increased absenteeism and turnover among employees with mental illness.

Some types of mental illness, such as anxiety and depression, are less severe and manifest sporadically over the life course. Other types of mental illness, such as schizophrenia and dementia, are more serious and persistent. Older adults experience many types of moderate to severe forms of mental illness: anxiety, delirium, dementia, depression, personality disorders, schizophrenia, and substance abuse. Some older persons may develop mental illness in childhood or adolescence, and endure the illness over their life course. Other older adults may have no history of mental illness until they experience a late-onset disorder such as dementia.

The Epidemiological Catchment Area surveys conducted by the National Institute of Mental Health (Regier et al., 1988) indicated that the prevalence rate among persons 65 years and older was 5.5% for anxiety disorders, 2.5% for clinical depression, 1.7% for substance abuse and .02% for schizophrenia. Moderate to severe cognitive impairment among older adults reached 4.9%. Regier et al. explained that the diagnosis of cognitive impairment corresponded most often with dementia rather than another neurological disorder, limited education, or developmental disability. The prevalence of mental illness among older adults is featured in Figure 1.

Moderate to severe mental illness constitutes the third or fourth most debilitating health problem affecting older adults, and as the population continues to age, the number of older adults with some form of mental illness will increase (Gatz, Lowe, Berg, Mortimer and Pedersen, 1994; Koenig, George, and Schneider, 1994; National Association of State Mental Health Program Directors, 1998). Manton, Corder, and Stallard (1993) added that, because the probability of being diagnosed with dementia increases with age, mental illness would become more common over the next 20 years as other chronic health conditions experienced by older adults such as arthritis and heart disease become more responsive to treatment interventions—thereby increasing life expectancy and the probability of acquiring dementia. In Figure 2, the prevalence of mental illness among older Americans is compared with other chronic health conditions.

Population aging and the imminent increase in the number of older adults with mental illness presents several challenges. If the prevalence rates of mental illness were used to measure the need for specialty mental health care, then the number of older Californians who currently require specialty mental health care exceeds 720,000. Between now and 2020, as the Baby Boomers age, the number of older Californians with mental illness is likely to reach 1.8 million.

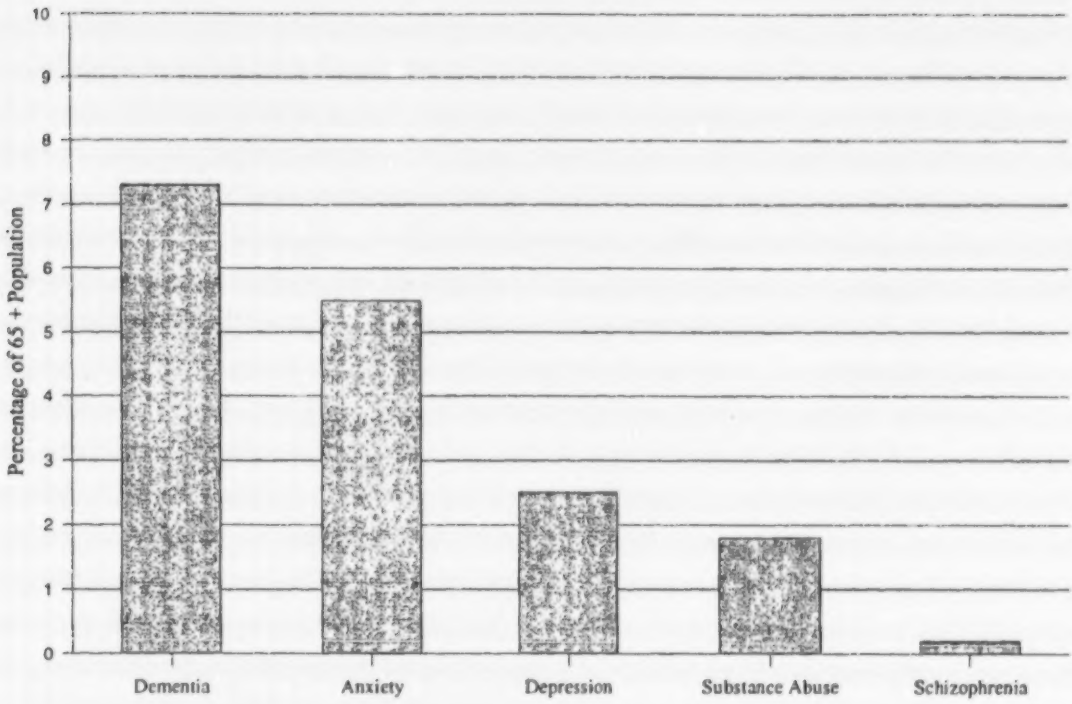
What can be done to promote mental health and prevent mental illness among older Californians? What are the most effective forms of treatment for older adults with mental illness? Who pays for these services? What are the disparities in the incidence of mental illness and the provision of specialty mental health services to older adults?

In the remainder of this report, we attempt to answer these questions by focusing on critical issues concerning: (a) the promotion of mental health and prevention of mental illness, (b) the provision of effective treatment, (c) the financing of specialty mental health services, (d) disparities across groups of older adults, and (e) emerging issues that warrant further consideration.

The Promotion of Mental Health and Prevention of Mental Illness

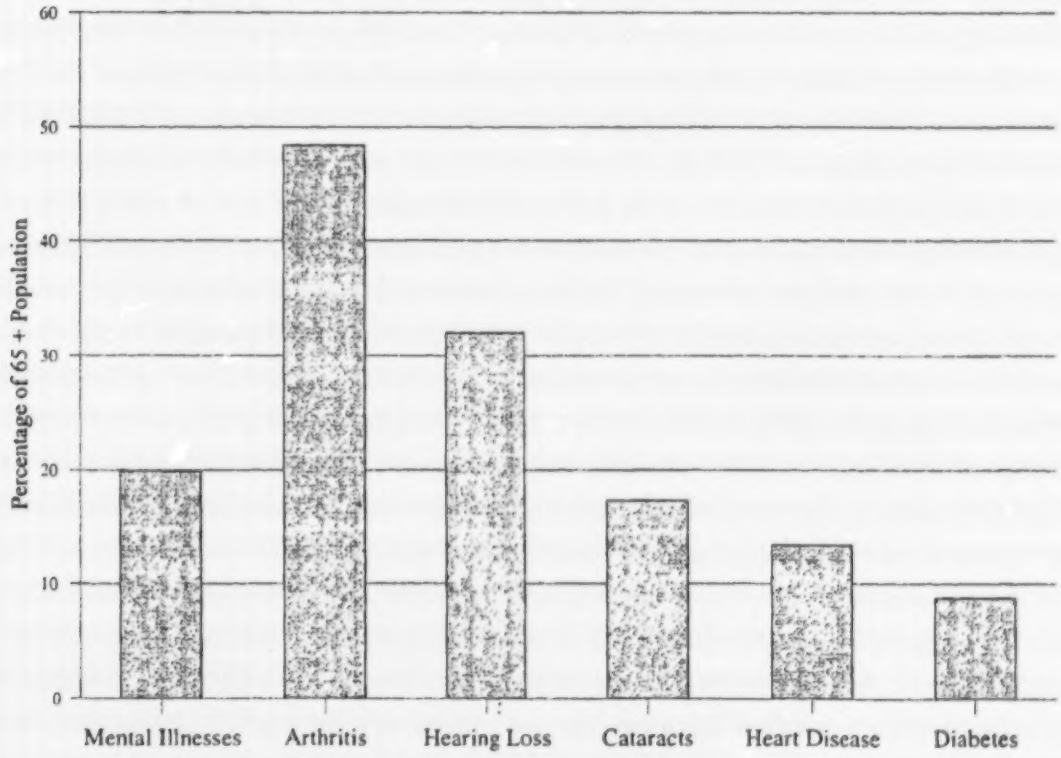
While the majority of older persons pass through the life course without any major psychological complications, the promotion of mental health and prevention of mental illness among older Californians should not be overlooked. Pearlin and McKean-Skaff (1995) argued that the coming generations of older adults will live longer, experience a greater number of health problems and physical disabilities, and endure changes to their family and social networks that are sure to present unique psychological challenges and conflicts. Older adults must prepare them-

Figure 1
Prevalence of Mental Illness Among Older Adults



Source: Regier et al., 1988

Figure 2
Comparison of Chronic Health Problems Among Older Adults



Sources: Regier et al., 1988; Statistical Record of Older Americans, 1994.

selves as they face such age-specific events as providing care to a demented spouse and coming to the end of life. The aging population should not presume that mental health and mental illness are unrelated to the aging process. Older adults must recognize that psychological well-being in late life must be pursued actively. Older adults must learn about the risk factors and early symptoms of late-onset disorders.

Margy Gatz and her colleagues at the University of Southern California (2000) identified a number of programs that effectively promoted mental health and prevented mental illness among aging populations. They found that relaxation training provided older adults with lasting benefits such as decreased blood pressure and lower levels of anxiety. Stress management programs increased the use of coping techniques and the sense of control among older participants. Memory training programs improved cognitive test performance among healthy older adults, and many of the participants reported that their memory improved more than the test results suggested.

The authors also reported that support groups for grieving older adults could prevent the onset of complicated bereavement. Bereavement support facilitated resolution to the grieving process, reduced anxiety and depression, and increased social interaction among widows and widowers. Support groups also identified resources that helped the individual adjust to living without his or her spouse or significant other. In addition, Knight, Lutzky, and Macofsky-Urban (1993) reported that support programs targeting caregivers of persons with dementia impacted levels of depression, stress, and physical health status.

Waters (1995) underscored the importance of providing outreach services to identify older adults at-risk for mental illness. The Surgeon General (2000) reported that depression was the primary risk factor for suicide among the older adult population, yet depression was not well-recognized by service providers.

This has stimulated the expansion of programs that increase public awareness and apply diagnostic screenings for depression. The Surgeon General also contended that depression and suicide prevention strategies were critical for nursing home residents, many of whom were at risk for depression subsequent to admission to a facility.

State Programs and Policies

The State administers a number of programs that promote mental health and prevent mental illness. Harrington et al. (2000) reported that the California Department of Mental Health (2000) administers 11 Caregiver Resource Centers (CRCs) that provide information, training and education, and technical assistance to persons who care for adults with debilitating brain disorders such as dementia, Huntington's disease, and Parkinson's disease. In Fiscal Year (FY) 1998, the state allocated slightly more than $5.0 million to the CRCs, which provided services to 10,200 persons. Moreover, the Department of Health Services (2000) administers 10 Alzheimer's Disease Research Centers that provide support groups, training and education, and service referrals. In FY 2000, the state allocated $3.9 million for these programs.

The California Department of Aging (1999) administers a number of programs that promote mental health and prevent mental illness. These include: (a) the Multipurpose Senior Services Programs, which received nearly $28 million and offered case management, adult day support services, and protective services to more than 9,000 older Californians; (b) the Adult Day Health Care, which received over $37 million and provided therapeutic and social services to more than 9,000 frail and functionally impaired older adults; and (c) the Alzheimer's Day Care Resource Centers, which received $3.7 million to provide respite services to 7,400 caregivers of person with dementia. These programs are featured in Table 1.

Table 1
Promotion of Mental Health and Prevention of Mental Illness: State Programs

Department	Program	Allocations	Number Served
Mental Health	Caregiver Resource Centers	5,000,000	10,200
Health	Alzheimer's Research Centers	3,900,000	10,000+
Aging	Multipurpose Senior Services	28,000,000	9,000
Aging	Adult Day Health Care	37,000,000	9,000
Aging	Alzheimer's Day Care Centers	3,700,000	7,400

Promotion and prevention efforts also are administered by other organizations. Several California universities provide education and training that focus on aging and mental illness. The Veteran's Hospitals in Long Beach, Los Angeles, Palo Alto, and San Francisco offer training in geriatric psychiatry and provide a range of services to older veterans with mental illness. Philanthropic organizations such as the Alzheimer's Association, Catholic Charities, and Jewish Family Services administer education programs and support groups for older adults. Private health organizations such as Kaiser Permanente and Alta Bates offer education and outreach to older adults with mental illness. We did not collect any information about the costs and number of persons served by these programs.

Efforts to promote mental health and prevent mental illness should be extended to medical care settings as well—to reduce psychological distress, depression, and health complications among older medical patients. For example, preventing the onset of delirium among older inpatients constitutes an important attempt to bridge mental health services into health care settings. Inouye et al. (1999) reported that patients who received a treatment intervention were significantly less likely to develop delirium than those who received usual care, and among the older adults who did become delirious, the patients who received active treatment experienced a shorter duration of the syndrome.

The application of this sort of prevention program in medical settings across California would certainly benefit older persons. In an evaluation of a general medical unit located in a San Francisco hospital, Kaskie (1999) reported the hospital had not established a program to prevent or treat delirium, even though the nursing staff estimated that as many as two out of three older

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patients appeared disoriented upon admission or became delirious soon after recovering from surgical anesthesia.

Provision of Effective Treatment

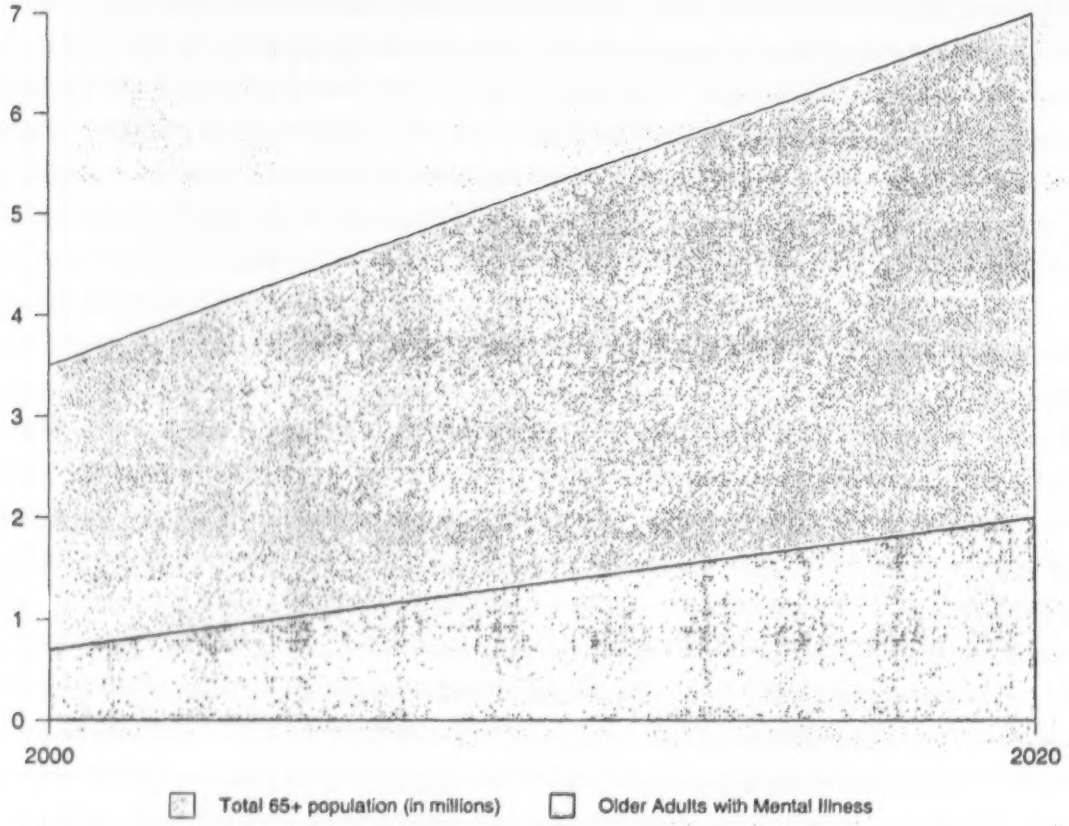
We reported that the number of older Californians who currently require treatment for mental illness is considerable (see Figure 3). While some of these illnesses could be averted or abated by programs such as those highlighted in the previous section, the majority of older adults who do suffer a mental illness require specialty mental health care. The provision of effective treatment can resolve a biologically based, late-onset illness such as depression. The provision of effective treatment can reduce the detrimental symptoms experienced by persons with chronic and persistent mental illnesses such as dementia.

Gatz et al. (1998) identified several well-established and/or probably efficacious psychological treatments for older adults. These included therapy for older persons with depression, treatment for sleep disorders, and memory training for persons with dementia. Schneider (1995) listed a number of pharmaceutical interventions that were effective with older adults diagnosed with anxiety, depression, mania, and other mental illnesses. Small et al. (1997) identified pharmaceutical therapies (e.g., tacrine, donepezil) for the treatment of dementia of the Alzheimer's type. Borson and Raskind (1997) reported that anti-psychotic drug therapies were effective in reducing secondary behavioral problems such as aggressiveness and hostility among persons with dementia. If older adults with mental illness received effective treatment, then quality of life would be improved dramatically—functional abilities could be maintained or recovered, occupational and leisure opportunities could be expanded, health status would be improved, and treatment could provide a cost savings to older individuals and their insurance providers.

Despite the availability of effective treatment options for older person with mental illness, treatment provision does not correspond very well with the need for services. It is known that only about one-quarter of adults who need mental health care ever get treatment, and the elderly are generally less likely to be diagnosed and receive treatment than the nonelderly. This lack of treatment provision is found across all service settings. Atay, Whitkin, and Manderscheid (1995) confirmed that the use of community-based mental health services by older adults was substantially lower than other populations. Lebowitz, Light, and Bailey (1986) added that 28% of Community Mental Health Organizations (CMHOs) did not retain a geriatric staff specialist or target any programs to older individuals suffering with any mental illness including dementia. Estes, Binney, and Linkins (1994) found that only 15% of CMHOs even listed the older population as a service priority.

Even among persons who did obtain psychiatric treatment, only about half were treated in the mental health specialty sector, and elderly patients were also less likely than other adults to be treated by mental health specialists or in specialty settings. Less than one-third of those who received physician services for a psychiatric condition saw a specialist (Ettner and Hermann, 1997). Ettner and Hermann (1998) documented that the majority of inpatient psychiatric care provided to older adults occurred within general hospitals, and this care often was provided in

Figure 3
Current and Future Prevalence of Mental Illness Among Older Californians



hospital scatter-beds instead of designated psychiatric units. Burns et al. (1993) reported that nearly two-thirds of older nursing home residents have a diagnosable mental illness but less than 5% received specialty mental health care.

Although some would argue that the use of general medical services by older adults with mental illness is beneficial, since generalists are capable of examining the concurrent medical problems presented by older adults with mental illness, the provision of mental health services by general medical providers may also be problematic. For example, family physicians and internists are more likely to overlook symptoms of mental illness. Callahan, Hendrie, and Tierney (1995) reported that more than 75% of a patient sample with cognitive impairment had never been diagnosed with clinical dementia by their primary health care provider. Other researchers established that primary health care providers rely excessively on pharmaceutical interventions to treat mental illness, and rarely refer older adults to specialty providers (Gottlieb, 1992).

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What prevents older adults with mental illness from obtaining specialty treatment? Blixen (1988) suggested that older adults may be reluctant to seek out care because of the stigma that has been attached to mental illness. Knight, Woods, and Kaskie (1998) added that older adults may be discouraged from obtaining specialty services because they are embedded within a perplexing array of medical and long-term care service organizations that may not provide access to mental health care. Moreover, older adults with no prior history of mental illness may not recognize symptoms that correspond with a late-onset disorder such as dementia. They interpret psychological symptoms as physical problems, and seek out a health care provider. In fact, Narrow et al. (1993) reported that the majority of older adults with mental illness initially sought treatment from a general medical provider.

Even if older adults actively sought specialty treatment, and/or primary care providers recognized mental illness and referred individuals to mental health professionals appropriately, Gatz and Finkel (1995) argued that the needs of older adults with mental illness would not be met because of the pervasive lack of professionals with clinical expertise in aging populations. There simply are not enough geriatric psychiatrists, gero-psychologists, and clinical social workers who are expert in the diagnosis and treatment of aging populations.

State Programs and Policies

The State can promote the delivery of effective treatment to older adults with mental illness in several ways. First, the state Departments of Aging, Health, Mental Health, and Social Services can ensure that the existing programs which promote mental health and prevent mental illness: (a) reduce the stigma of mental illness, (b) educate older persons about how to access specialty care, and (c) demonstrate how early symptoms of mental illness can be identified and distinguished from physical complications.

The state also can promote the education and training of health and mental health professionals who care for older adults with mental illness. During the 2000 session, for example, the California Legislature passed AB 1753. This law requires the staff of nursing facilities to complete continuing education that focuses on providing care to demented and mentally residents.

Perhaps most important, the California Department of Mental Health can make a more concerted effort to monitor the provision of publicly funded mental health services to older populations. Kaskie, Wellin, and Harrington (2000) reported that since the Bronzon-McCorquodale Act was passed in 1991 (i.e., mental health services realignment) the Department of Mental Health has neither targeted services toward older populations nor conducted a thorough evaluation of the services that are provided to older adults. The state only collects information concerning the costs and number of individuals who received services in the state hospitals and by the County Mental Health Departments. Whether or not the state is providing effective treatment to older adults with mental illness is unknown.

Financing Mental Health Services

Our preceding recommendations to promote mental health, prevent mental illness, and increase the delivery of effective treatment to older adults with mental illness are not without historical precedent. The President's Commission on Mental Health introduced a similar set of proposals in 1977, and these were reiterated at the 1995 White House Conference on Aging (U.S. Department of Health, Education, and Welfare, 1978; Gatz, 1995).

However, Knight and Kaskie (1995) cautioned that any effort to promote mental health, prevent mental illness, and provide effective treatment to older adults also required the support of the primary purchasers of mental health services: Medicare and Medicaid. In planning for the psychological well-being of the growing population of older adults, the State must consider how (and how well) Medicare and Medi-Cal policies promote mental health, prevent mental illness, and support the provision of effective treatment.

Medicare Mental Health Services

A significant number of specialty mental health services used by older adults are financed by Medicare, the federal insurance program that provides health coverage to more than 95% of Americans aged 65 and over. In 1980, Medicare allocated nearly $900 million for specialty mental health care and, by 1990, Medicare Part A reimbursements for inpatient psychiatric services amounted to slightly more than $1.0 billion, and Part B claims, which are submitted by professionals who provide mental health services within inpatient, partial, or outpatient settings, amounted to $370 million (Ettner and Hermann, 1998; Goldman and Frank, 1991; Rosenbach and Ammering, 1997). While these data indicated that Medicare increased spending significantly, a more revealing statistic suggested that the expenditures for mental health services consistently represented less than 3% of all Medicare expenditures during this period.

Roybal (1984), Gatz and Smyer (1992), and several others have commented that the Medicare program simply has not provided sufficient levels of financial support to meet the service needs of older adults with mental illness. In fact, the agenda setting efforts conducted by the Senate Special Committee on Aging (1971), the House Select Committee on Aging (1976), and the President's Commission on Mental Health (1978) all suggested that the Medicare program must develop and expand policies that promote mental health, prevent mental illness, and support the provision of effective treatment.

In recent years, the Medicare program responded to these calls and implemented a number of policies designed to increase the provision of specialty mental health services. Pursuant to the Omnibus Budget Reconciliation Acts of 1987 and 1989, for example, the Health Care Financing Administration (HCFA) increased the lifetime limit of inpatient care provided in psychiatric hospitals to 190 days. HCFA also rescinded annual reimbursement limits for outpatient mental health services. Further, Medicare expanded the list of qualified mental health providers to include licensed clinical psychologists and licensed clinical social workers (Rosenbach and Ammering, 1997; Smyer, Shea and Streit, 1994).

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While these policies may have contributed to increased use of mental health services among older Medicare beneficiaries, Ettner (1997) commented that the Medicare mental health policies were biased so that providers were encouraged to offer care in general health care settings rather than specialty mental health service organizations. Her inspection of the Medicare service reimbursement policies also revealed that the 190-day lifetime limit on inpatient care was imposed on care provided within specialty psychiatric hospitals, but no comparable limit was imposed on care provided in specialty psychiatric units within general hospitals. Moreover, while a daily limit was set on the services provided by psychiatrists, no limits were imposed on services provided to older adults with mental illness by general medical doctors. Finally, Medicare approved a 20% co-payment for the management of pharmacotherapy, but maintained the 50% co-payment for outpatient psychotherapy. Taken together, these policies suggest that the Medicare program still falls short in promoting the provision of specialty treatment to older adults with mental illness.

Casciani (1999) claimed that the Medicare policies have discouraged the provision of clinically appropriate care to older adults living in California. In particular, he reported that the Medicare fiscal intermediary that reimburses mental health services in California has rejected or adjusted a number of billing claims made by mental health professionals that serve older adults in San Diego County. While Medicare was established as a federal program, the state should consider how Medicare intermediary policies preclude older adults with mental illness from receiving effective treatment.

Medi-Cal Mental Health Services

When the Medi-Cal program was created in 1966, qualified older adult beneficiaries were eligible to obtain mental health services fron. California's state psychiatric hospitals, county institutions for mental disease, and nursing homes. Older Medi-Cal beneficiaries also were eligible to receive outpatient services within the community mental health organizations operated by the County Departments of Mental Health, as well as from independent psychiatrists and psychologists who were qualified Medi-Cal providers (California Department of Mental Health, 1994).

In 1991, the State passed the Bronzan-McCorquodale Act (aka Mental Health Service Realignment). The act intended to increase coordination across service settings, promote the use of the most effective and least restrictive care, and contain the escalating costs of publicly funded mental health services. The California Department of Health Services, which finances specialty mental health care for Medi-Cal beneficiaries, followed suit and obtained a Medicaid 1915(b) waiver to facilitate the implementation of community-based services and capitate reimbursements for Medi-Cal mental health services. This was known as the Medi-Cal Managed Mental Health Care Plan of 1994 (Kaskie, Wellin, and Harrington, 2000).

The state Department of Mental Health reported that in FY 1997 a total of 382,423 individuals received mental health services. Of these, 16,438 were 65 years or older (4.3%). Further inspection of the data indicated that 75% of the older adults who used mental health services were Medi-Cal beneficiaries. In Table 2, we present additional figures to reveal two critical trends. First, even though the total number of individuals who received mental health services

increased from 1990 through 1998, the absolute and proportional number of older adults who received services steadily decreased. Second, the number of services provided to individuals with cognitive impairment has been cut in half during the last decade.

So, the reform of California's publicly funded mental health system met the broadly defined objective of containing expenditures while maintaining client access, as measured by the total number of individuals who received publicly funded mental health services (Scheffler and Wallace, 1999). However, upon closer inspection of the older adult population, the reform actually corresponded with decreased access and provision of specialty mental health services.

Why this happened remains unclear. Did older adults receive mental health care from Medicare providers instead? Did older adults pay for specialty services with their own money? Did older adults with mental illness substitute specialty treatment with some other form of care? Did older adults just not receive any specialty mental health care at all? Was this a deliberate strategy or just an unintended consequence of the reform? Answers to these questions can contribute to the development of more effective Medi-Cal policies that increase the delivery of mental health services to California's aging population.

Issues of Diversity

So far, we have focused on contemporary issues concerning the mental health of California's aging population. We suggested that programs to promote mental health and prevent mental illness must be expanded, efforts to provide effective forms of treatment must be increased, and policies that pertain to the financing of these endeavors must be improved. We recognize that these are encumbering tasks, especially when juxtaposed with the many others highlighted in these reports. We also recognize that the complexity of these challenges will only intensify as the California population ages and becomes increasingly more diverse. Questions to be considered in the next 10 to 20 years will become more intricate and difficult to answer.

What can be done to promote mental health and prevent mental illness among older Californians who are foreign-born and speak English as a second language? What are the most effective forms of treatment for older adults who may have different cultural definitions of mental health and mental illness? Who will pay for mental health services required by someone who does not qualify for public programs because he or she is an illegal elder immigrant from an impoverished country?

Gatz, Kasl-Godley, and Karel (1996) documented how the prevalence of mental illness among older adults varies by gender and ethnic status. They reported that major depressive disorders, dysthymia, and anxiety disorders were twice as common among older women than older men. Other researchers have suggested that the prevalence of depression is higher among older Hispanics, and dementia is more common among older African Americans.

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Table 2
Costs and Use of Mental Health Services by Older Californians: 1990–1998

	1990		1994		1998	
State Population	30,296,000		31,661,000		33,226,000	
Clients	320,704		341,278		382,423	
Clients per 1,000	10.6		10.8		11.5	
	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT
Clients by Age	320,704	100.0	341,278	100.0	382,423	100.0
0–12	32,497	10.1	34,982	10.3	51,231	13.4
13–17	32,937	10.3	37,349	10.9	50,835	13.3
18–20	12,102	3.8	11,791	3.5	14,331	3.7
21–39	139,512	43.5	142,245	41.7	127,895	33.4
40–59	77,591	24.2	90,296	26.5	111,360	29.1
60–64	**8,644**	**2.7**	**8,483**	**2.5**	**9,651**	**2.5**
65+	**17,041**	**5.3**	**15,748**	**4.6**	**16,438**	**4.3**
Unknown	380	0.1	384	0.1	682	0.2
Clients by Diagnosis	320,704	100.0	341,278	100.0	382,423	100.0
Schizophrenia	49,788	15.5	46,980	13.8	60,171	15.7
Bipolar Disorders	22,249	6.9	26,307	7.7	30,975	8.1
Depressive Disorders	63,852	19.9	73,446	21.5	102,070	26.7
Other Psychoses	30,346	9.5	37,469	11.0	27,074	7.1
Adjustment Disorders	47,674	14.9	36,988	10.8	36,854	9.6
Childhood Disorders	27,770	8.7	31,618	9.3	43,582	11.4
Substance Use	13,239	4.1	17,666	5.2	18,594	4.9
Cognitive	**6,349**	**2.0**	**5,848**	**1.7**	**3,990**	**1.0**
Other Nonpsychotic	34,816	10.9	35,435	10.4	34,571	9.0
Unknown	24,621	7.7	29,521	8.7	24,542	6.4

However, Estes (1995) reported that data concerning the costs and mental health service among women and minority populations were sparse. Moreover, it remains unclear how gender and cultural differences correspond with different treatment outcomes. Do women respond better to one type of prevention program than another? Are mental health professionals able to diagnose depression more accurately among older adults who speak English as their first language? Researchers only can speculate about how the increasing diversity of the aging population may or may not correspond with increasing problems related to the access and delivery of mental health services. Nevertheless, Greene (1995) suggested that ignoring these issues would curtail service use among older Californians.

We also contend that issues concerning diversity should not be limited to gender and ethnicity. We suspect that the provision of effective treatment also varies according to the particular diagnosis. For example, the Medicare and Medi-Cal programs deliberately exclude persons with

dementia from the limitations imposed on the delivery of services to other groups of older adults with mental illness. Whether or not these targeted policies will continue over the next 20 years remains uncertain. Will services only be provided to older adults with certain types of mental illness?

Emerging Issues

Beyond embracing the challenges of an increasingly diverse older adult population, we identified two issues that may become more critical in the next 10 to 20 years. The continued growth of managed care should impact the delivery of specialty mental health services substantively, and efforts to integrate aging, health, long-term care, mental health, and social services into a coherent system of care should impact older Californians as well.

Managed Care

The expansion of managed behavioral health care during the 1990s has been tremendous (Goldman, McCullough, and Sturm, 1998). The number of older Californians who have enrolled in managed care organizations and, consequently, receive mental health services within a managed care setting has reached 37% of all Medicare beneficiaries living in the state (Kaiser Foundation, 1999). As mentioned earlier, Medi-Cal has implemented a waiver program that applied managed care techniques to fix annual expenditures for all mental health services delivered to older Medi-Cal beneficiaries (Kaskie, Wellin, and Harrington, 2000).

Knight and Kaskie (1995) as well as Ettner (1997) have commented about the potential advantages and problems with shaping the delivery of mental health with managed care techniques and providing services within managed care organizations. Managed care organizations emphasize screening and early detection to promote mental health and prevent mental illness and, in some cases, may provide greater continuity of care and better integration of medical and behavioral treatment. Managed care organizations also provide enhanced prescription drug coverage, potentially providing a significant cost savings to an older adult with mental illness.

On the other hand, managed care organizations may selectively enroll the most healthy older individuals to the exclusion of people with preexisting conditions such as a life-long mental illness. In addition to directly limiting care through utilization review and other gatekeeping mechanisms, managed care organizations often fix or capitate service reimbursements. This creates a strong incentive for professionals to limit the provision of intensive services such as weekly psychotherapy.

Empirical evaluations of how managed care affects older adults with mental illness have been few, and these studies are not sufficient to reach definitive conclusions. Wells et al. (1993) found that the application of prospective payment, a technique characteristic of managed care practice, reduced the average length of inpatient care among older Medicare beneficiaries, but the reduction did not alter treatment outcomes. In contrast, we determined that the application of capitated financing decreased access to services among older Medi-Cal beneficiaries (see Table 2).

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So, while enrollments in managed care organizations continue to increase and the application of managed care techniques expands, we find it difficult to resolve whether or not our general concerns with promoting mental health, preventing mental illness, and providing effective treatment are being met. The State should support more critical evaluations and monitor exactly how managed care impacts older adults who suffer with mental illness. This information may become even more critical in the future, if the burgeoning Medicare costs associated with the aging of the population leads policymakers to propose making enrollment in managed care plans mandatory for all Medicare beneficiaries, rather than voluntary.

Older Adult System of Care

The California Department of Mental Health implemented systems of care programs to promote access to effective forms of mental health treatment in the least restrictive settings. The systems also were designed to integrate service delivery across several organizations, and contain overall costs of providing care to a targeted population (Attkisson et al.,1999; California Department of Mental Health, 2000). These objectives were achieved by creating a single point of contact for service users, applying a uniform assessment and treatment protocol, coordinating the delivery of health, mental health, and social services, and consolidating funding streams so that services are financed by a single agency.

In 1988 the State of California provided funding to the Department of Mental Health to develop a county-based system of mental health care for children with serious mental illness. By 1998, no less than 52 counties had implemented some version of a children's system of care (Department of Mental Health, 2000). The system of care model also has been targeted successfully to homeless mentally ill populations. In Los Angeles County (2000), for example, the Adult Targeted Case Management Program reduced the costs of mental health services by 25% while increasing the use of case management, outpatient services, and vocational programs among more than 600 mentally ill adults.

The California Senate (1999), the Older Adult System of Care Committee (2000), and the California Alliance of Older Adults with Mental Illness (2000) have asked the State of California and the Department of Mental Health to develop a system of care for older adults. The groups argued that a system of care targeting the aging population would: (a) improve or maintain the mental health of older adults and (b) reduce the aggregate costs of providing publicly funded services to the aging population.

In response, the California Department of Mental Health recently allocated more than $2.0 million for the development of the Older Adult System of Care Pilot Program (Department of Mental Health, 2000). This constitutes a critical advance in the state's response to older adults with mental illness. If the initial efforts to develop the Older Adults System of Care meet the objectives outlined above, then the state will have taken a giant leap toward meeting the needs of older adults with mental illness. This system of care initiative should be monitored closely, and any successful outcomes should be replicated across the state. Indeed, the California Department of Mental Health should be prepared to expand the effort in response to continued growth of the aging population.

DISCUSSION

Summary

Older adults represent slightly more than 1 out of every 10 persons living in California. As the Baby Boomers age over the next 20 years, the graying of the state will become more apparent and the proportion of older adults may reach 20% of the total population. Population aging presents many unique challenges, and some of these concern the promotion of mental health, prevention of mental illness, and provision of effective treatment to older adults.

We have argued that there are more than 700,000 older Californians that currently require specialty mental health care, and this number may triple by the year 2020. Providing effective services to these individuals, as well as promoting mental health and preventing mental illness among the remaining population, can significantly enhance the quality of life among older Californians. Functional abilities would be improved, maintained, or recovered; occupational and leisure opportunities would be expanded; health status would be improved; and other benefits could be achieved on individual and societal levels.

We highlighted how the State already has taken steps toward addressing matters concerning psychological well-being. The departments of Aging, Health Services, Mental Health, and Social Services all provide services that promote mental health, prevent mental illness, and offer specialty treatment. We also reported how the California Legislature has made important advances as well. This year, in fact, the legislative body approved a bill that requires the staff of residential care facilities to complete formal training concerning the care of persons with dementia and other forms of mental illness.

We also pointed out where the State could improve. Programs must be expanded so that more older adults can be served. The state also should reconcile how recent reforms to the Department of Mental Health and the Medi-Cal program have decreased access to publicly funded mental health services for the older population. We also contended that the state ought to take a careful approach to evaluating such issues as: the integration of mental health services into medical care settings, the provision of effective services by the county departments of mental health, the Medicare policies that may deter the provision of effective treatment, the impact of the increasing diversity of the aging population, the role of managed care in mental health, and the development of a statewide system of care targeting older adults.

Our concern with these particular issues is consistent with several other groups that have advocated on behalf of older adults with mental illness. In the last year alone, the California Council on Aging, the California Alliance of Older Adults with Mental Illness, and the California Mental Health Directors Association have highlighted the problems that face older adults with mental illness.

Beyond illuminating efforts taken (or that could be taken) by the State of California, we also featured a number of efforts undertaken by universities and private organizations such as the Alzheimer's Association and Kaiser Permanente. While we did not collect any specific data that

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allowed us to determine the impact of these efforts, we are certain that these organizations assume a critical role in promoting mental health, preventing mental illness, and providing effective treatment. Older adults with mental illness are a growing population, and as such, they should place a greater demand upon private organizations to meet their needs. The state should encourage the development of this emerging market as another viable response to the needs of the aging population.

Points for Consideration

To summarize, we identified six key points:

1. The prominence of mental illness among the aging population should increase over the next 20 years, and mental illness will constitute the second or third most prevalent health problem affecting older adults.

2. Efforts to promote mental health and prevent mental illness should be expanded.
   — California should augment programs administered by the departments of Aging, Health Services, Mental Health, and Social Services, and these efforts also should be expanded into medical care settings as well.
   —This activity should not be limited to public agencies; other organizations should expand their efforts and compile information that provide some reflection of impact.

3. Since effective treatments for mental illness among the aging have been established, a more concerted effort must be taken to increase the use of these services by the aging population.
   — Older adults must be educated about mental illness.
   — Health and mental health professionals should acquire expertise in the assessment, treatment and appropriate referral of older adults.
   —The California Department of Mental Health should make a more deliberate effort to target services to the aging population, collect data on the provision of care, and evaluate the outcomes of service delivery.

4. Since the Medicare program finances the majority of mental health services provided to older Californians, the state should consider how Medicare policies can be improved. Attention should be specifically directed toward the discrepancies between the California Medicare fiscal intermediary and individual service providers.

5. The state should resolve why the recent reforms in the Department of Mental Health and the Medi-Cal program decreased access to publicly funded mental health services among older populations.

6. Three emerging issues warrant further attention:
   — the increasing diversity of the aging population
   — the expansion of managed mental health care
   — the development of a statewide older adults system of care.

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